

UNNATURAL CAUSES **Is Inequality Making Us Sick?**

A Four-Hour Series and Public Engagement Campaign

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Contact

Larry Adelman, Executive Producer
LA@newsreel.org;

Rachel Poulain, Director of Outreach
RP@newsreel.org

California Newsreel
500 Third St., #505
San Francisco, Ca 94107
415-284-7800
www.newsreel.org

SUMMARY

Shortly after Hurricane Katrina, a FEMA official, rationalizing the agency's inadequate response to the storm, noted that FEMA had run many different emergency simulations to evacuate New Orleans but each had overlooked one thing: "We never anticipated that so many of the poor would be so sick."

What FEMA failed to recognize then (as many pondering the lessons of Katrina continue to overlook still) was that the poor of New Orleans, like the poor throughout the country, had spent their lives being battered by hundreds of mini-Katrinass in the shape of social and institutional abuse, deprivation and neglect. These "tempests of daily life" take a huge, cumulative toll on the body over the years. The wear and tear of a lifetime of weathering was starkly evident in the large numbers of poor and African American 40-, 50- and 60-year-olds – relatively young people - who limped and wheezed into the New Orleans Superdome and Convention Center with their oxygen, insulin, canes and wheelchairs.

Unnatural Causes is a four-hour limited series that will for the first time on television sound the alarm about our huge and disturbing socio-economic and racial/ethnic disparities in health--and

search for their causes. But those causes are not what we might expect. While we pour more and more money into drugs, dietary supplements, and new medical technologies, and we focus on what we as individuals can do to be healthier, *Unnatural Causes* criss-crosses the country investigating the growing body of evidence that suggests there is more to our health than bad habits, our meds, or unlucky genes. As it does so, it circles in on a slow killer in plain view: The social circumstances in which we are born, live and work can actually get under our skin and put us at risk for stroke, heart disease, asthma, hypertension, diabetes, kidney disease, even cancer.

Note that the series will not simply illustrate differential health care access and treatment but why some populations get sicker more often in the first place, i.e. the role of inequality, racism, poverty, segregation and neglect in breeding disease and despair.

There are by now thousands of studies tracing the social determinants of health. Yet the popular perception remains that poor and minority populations, like those left behind in New Orleans, get sick as a result of bad genes or because they lack the character and discipline to eat right, exercise and abstain from drugs and booze. Similarly, most Americans still believe it's top executives who are dropping dead from heart and artery disease when in truth it's their subordinates. There is virtually no popular media that brings the research-based counter-story to policy makers, engages a broad public, and can mobilize impacted communities.

Unnatural Causes will not dismiss the role individuals can play in safeguarding their own health. On the contrary, healthy behaviors are critical. But they're only one part of the picture. As University of Michigan epidemiologist (and series advisor) David Williams points out, increasing opportunities, providing education and training for better jobs, investing in our schools, improving housing, integrating neighborhoods, giving people more control over their work – these are as much health strategies as diet, smoking, and exercise. These are the stories *Unnatural Causes* will tell.

Broadcast in tandem with an ambitious public engagement and outreach campaign conducted in association with leading health, public policy and community-based organizations, *Unnatural Causes* can confront American myths and misconceptions about our health and stimulate a broad debate about what we as a society can and should do to reduce our glaring health disparities.

OBJECTIVES

What's happening to our health? The United States, the richest country in the world, spends twice per person on health care than any other nation. Yet American life expectancy ranks 29th; Costa Ricans live longer. Infant mortality? We're tied with Hungary, Poland and Slovakia for next to last among the industrialized nations. Illnesses cost American business \$260 billion year in lost productivity.

Unnatural Causes explores a paradigm shift that connects our health not just to individual behaviors and health care but to underlying social conditions. As Sir Michael Marmot, chair of the WHO's new Commission on the Social Determinants of Health put it: "Real people have problems with their lives as well as with their organs. Those social problems affect their organs."

In order to improve public health, we need to improve society.” The following six objectives underscore how the series can help move our health discussion “upstream”:

- Increase public awareness of the alarming socio-economic and racial disparities in health and their human and financial costs.
- Promote understanding of the pathways by which class, racism and disempowerment get under the skin and influence health outcomes
- Inject considerations of social and economic policy--around housing, racism, education, jobs and wages, community development, social supports, and tax policy--into discussions of health; and evaluate social and economic policies by their impact on health.
- Demonstrate to the white middle classes that health disparities are not limited to the poor and people of color but harm them too
- Draw public and policy-maker attention to innovative community-based initiatives for health equity
- Provide a new health ‘story,’ one that connects the conventional American frame of individualism (in this case our desire for a healthy life) to a new language of connectedness, a story that centers social justice and empowerment as fundamental to individual health and well-being.

Unnatural Causes will demonstrate that inequality and racism are not abstract concepts but hospitalize and kill even more people than cigarettes. "There is an Axis of Evil," David Williams says, "an Axis of Evil of inequality, of racism, of poverty, of economic deprivation that is adversely affecting the health of the American people." Our nation has a choice: We can address the racial and economic inequalities that lead us down the path to disease now. Or we can pay to repair the bodies later.

KEY THEMES

This is a series about how both class and racism affect health. It's long been known—and is rather obvious--that the poor have worse health than the rich. Edwin Chadwick's Sanitary Report warned back in 1842 that squalid conditions were devastating England's urban poor. But it was the pioneering Whitehall studies of the British civil service that turned heads when it revealed unmistakable evidence of a health gradient that runs throughout society.

What Whitehall found surprising was not just the four-fold difference in morbidity and mortality between the top and bottom quartile of English civil servants, but that those in Level Two--professionals and managers and lawyers one step below the top--had rates of disease twice as high as the executives running the departments.

This same health gradient has since been found for virtually every disease in every industrialized country in the world. Whether measured by income, by educational attainment, or by occupational status, there is a socio-economic gradient to health. And the greater the inequality in a society, the steeper the gradient. The United States has the greatest inequality of all--and the greatest health disparities.

Yet at each socio-economic level, African Americans are worse off than their white counterparts. In many cases, so are other populations of color. And the mortality gap has been growing. U.S. Surgeon General Dr. Davidatcher and his colleagues calculated that in 2002, 83,570 African Americans died who would not have died if black-white differences in health did not exist, a rate of 229 "excess deaths" per day. That's the equivalent of one Boeing 767 being shot out of the sky and killing everyone on board every day, 365 days a year. And they are all black. According to a by-now landmark study by Drs. Colin McCord and Harold Freeman, African American males over age five in Harlem are less likely to reach age 65 than men in Bangladesh. Among Latinos, the prevalence of diabetes is 100% higher than among white Americans.

But how do socio-economic status and racism affect our biology? Through what channels does inequality--the cumulative disparities in housing, wealth, jobs, and education, combined with the lack of power and control over one's life--translate into bad health? What is it about our poor neighborhoods, especially poor neighborhoods of color, that is so deadly? How are the lifestyle choices we make (e.g. diet and exercise) constrained by the choices we have?

There's controversy, of course, over the most critical pathways that lead from inequity to disease and how best to address our health crisis. But as we tap into the research, several themes are emerging that will inform our series. These include:

1. The environment as an independent, disease-causing factor. How can a neighborhood become what Amani Nuru-Jeter has termed "a reservoir of disease pathogenesis"? Why, for example, is cancer more common among poor people who smoke the same number of cigarettes as rich people? The environmental justice movement has shown us how disadvantaged neighborhoods and communities of color face greater exposure to pathogens and carcinogens - polluting industries, lead paint, asbestos, water pollution, and toxic waste and landfill sites.

But differential exposure to chemicals and other pollutants is only part of the picture. Columbia University's Mindy Fullilove, Harvard's Dolores Acevedo-Garcia and many others are investigating how the social, economic and physical characteristics of a place, especially the oppressive conditions of poor, segregated urban space, can affect health, both directly and by influencing behaviors. We know that smoking, diet, drinking and lack of exercise are huge risk factors for disease. What we don't readily acknowledge is that behavior isn't just a mark of individual character strength.

A tour of two neighborhoods--one wealthy, one poor--can help us understand what kind of built environments engender healthy choices. Are there supermarkets and produce stores nearby with fresh produce or just fast food joints, liquor stores and mom-and-pops immersed in a sea of liquor and cigarette billboards? A safe place to walk, jog, bike or play? Is the neighborhood a happy place to be? How much green space? Good schools with gym classes, art, music and after-school programs? And how does access to what Harvard's Ichiro Kawachi refers to as "social capital" - including mutual trust, social networks, and community efficacy - affect physical as well as mental well-being?

2. The social environment as a source of chronic stress. The lower one's position in the socio-economic hierarchy, the greater the exposure to stressful life events such as job loss, eviction, death, crime, and sickness and the larger the impact of these events on psychological well-being. But the on-going hassles of daily life are also more formidable and stressful in disadvantaged neighborhoods than in wealthier, white neighborhoods--dealing with poor schools, lousy and time-consuming transportation, unresponsive or over-aggressive police, lack of childcare, imperious or racist supervisors at work.

Researchers like Rockefeller University's Bruce McEwen and UCLA's Teresa Seeman are circling in on the biological pathways by which the chronic stress response can actually change our physiology, especially our neuro-endocrine, immune and cardiovascular systems. McEwen calls this measurable wear-and-tear of persistent micro-insults to the system *allostatic load*. He and Seeman are demonstrating how chronic stress puts people at risk of immune system suppression, increased glucose levels, obesity, heart and artery disease, depression, and even impaired memory. As Stanford's Robert Sapolsky points out: Turn on the stress response for five minutes and it can save your life; turn it on for 30 years and it puts you at risk for every disease of western man.

There's also increasing evidence that repeated exposure to stressors early in life inhibits children's ability to develop "resilience," increasing the chances they will develop helplessness and depression later in life, additional high risk factors for obesity and illness.

3. Power and control. England's pioneering Whitehall studies turned conventional wisdom on its head when it uncovered that it's not high-powered executives who are made sick by stress but their underlings. This finding isn't as counter-intuitive as it seems once we understand that pressure can either be an invigorating challenge or a health-damaging threat. Which one depends not only on the demands made but whether the individual perceives that he or she has the power and resources to cope with those demands. Executives usually do. But power and control over one's life decrease with each step down the socio-economic ladder. The lower people are in the hierarchy, the greater they struggle to access the money, power, status, knowledge, social connections and other resources needed to manage and gain control over the many tempests that threaten to upset their lives.

But it's not only those at the bottom of the ladder harmed by lack of power. So are many middle managers, working people, and especially people of color. High demand / low control jobs are particularly risky. City bus drivers, for example, must keep to a schedule and are penalized when they are late (or early). Yet bus drivers have no power over traffic and unruly passengers. 80% of San Francisco city bus drivers over age 50 suffer hypertension.

Further down the ladder, stressors mount—and health worsens. That becomes clearer if we look at the women working the gut line at a catfish plant, cashiers on the night shift at 7-11 stores, stock clerks at Wal-Mart, or cleaners of office buildings. Their hopes may be modest - climb up the job ladder, buy a home, send their kids to a good school, a decent life - but their aspirations to succeed are often thwarted by barriers of an interpersonal and institutional kind over which they have little control, including prejudice and racism. This is the stress of marginalization.

Interestingly, Whitehall and other research suggest that above a certain threshold relative wealth and income inequality seem to have a bigger impact on health than absolute wealth. This is still a controversial finding. Perhaps one explanation for this can be found in how inequality and stratification increase feelings of hopelessness, frustration and despair among those closer to the bottom. How social status and hierarchy are linked to health has been studied by Robert Sapolsky and other scientists observing patterns of dominance among baboons and macaques. Several experiments are now beginning to demonstrate that when humans--families and communities--have the resources and power to take more control over their lives, their health improves.

4. Genetic reductionism and the myth of innate racial difference. So, despite these findings, why are millions of dollars still rushing into SNP studies and pharmacogenomics in a search for the holy grail of genetic differences between "races" to explain health disparities while attempts to research and mitigate the impact of social conditions go begging? A story such as BiDil - the new cardiac medicine aimed at African Americans and which is being touted as the first 'racial' drug - reveals the reward system that drives so much health policy and research in America. Such emphasis on genetic causes of racial health disparities may not only be misguided but, by reviving old ideas of innate differences between 'races,' distracts attention from the underlying social determinants of health and lets society off the hook. As medical anthropologist William Dressler has said, "So many medical conditions are differentially distributed to African Americans - heart disease, diabetes, hypertension, low birth weight babies - are we to believe that black people were so evolutionarily unlucky that they got all the genes that predisposed them to every malady?"

In contrast, Dressler, Sherman James, Richard Cooper and others have been investigating why African Americans have among the highest rates of hypertension in the world. This was long assumed to be genetic, a marker of 'blackness' itself. But then it was discovered that West Africans have among the world's lowest hypertension rates, lower than white Americans. What is it about the lived experience of African Americans, as opposed to 'black' genes, that could be creating biological feedback loops with profound consequences for health? The NIH's CARDIA study (Coronary Artery Risk Development in Young Adults), which has been tracking 5,000 black and white Americans in four cities over 15 years, provides another opportunity to isolate the social risk factors for coronary artery disease.

5. The interplay of race and class. While socio-economic status has huge consequences for health, the impact of race is additive and can be found both upstream and independent of class. Upstream, educational, housing and wealth-accumulating opportunities have been shaped by a long history of racism that confers advantage to some groups while disadvantaging others. But racism also works its pathology through several other vectors: isolated and segregated space, the cumulative impact of persistent racist micro-insults on chronic stress, the degree of hope and optimism people have, the location of doctors and hospitals, and differential access to and treatment by the health care system. Each adds an extra burden to people of color no matter what their class. But how do you measure the impact of racism? Several projects are looking into this, including the Centers for Disease Control's Measures of Racism Working Group and the National Research Council.

6. Cumulative disadvantage. Our series is also informed by the understanding that risk factors are cumulative, their impact growing through the life course. Pre-natal and childhood exposures and deprivations matter later in life, even if that child eventually carves a path into the upper middle class. “You can move up,” observes Makani Themba-Nixon, executive director of The Praxis Project, “but you can’t move away.”

Moreover, the sources of health outcomes stretch back even further in time than conception to past generations. What happened in the past matters today and sets the starting line for the future. Parents with health deficits tend to have lower birth weight-babies and less healthy children. But perhaps more importantly, wealth is also inherited. Economists estimate that up to 80% of family wealth comes from intergenerational transfers and the worth of one’s home. Socio-economic status is very much affected by our past history of discrimination, segregation and racialized markets. Today the median household net worth of white families is an astonishing ten times that of African American families, more than eight times that of Latino families. And that wealth gap has been growing not narrowing. The chances of someone being born poor and growing up to reach the upper middle class are worse today than they were 100 years ago. England, the very symbol of the static, class-cleaved society, now has more class mobility than we do. Horatio Alger is dead.

7. Making a Difference. The structural obstacles to good health can sometimes seem so entrenched and overwhelming that people feel there’s nothing they can do. But on the contrary, experience suggests that small changes can yield big benefits. We can see this in other countries and in communities throughout our own. In Seattle, Washington, a collaboration between community groups, the public health department and the housing agency has resulted in a new mixed-income community, High Point, that explicitly addresses neighborhood health threats while recouping some of its costs through reduced Medicare spending on its residents, especially for asthma and diabetes. Oakland, California is funneling public health agency funds to community organizing in its El Sobrante neighborhood with the expectation that an empowered citizenry is a healthier citizenry. A large American manufacturer, with prodding from its union, is pushing power and responsibility downward, giving its employees a greater stake and a say in their jobs as a way to help cut their staggering health care costs and reduce sick days. The Pima Indians south of Phoenix have reclaimed their traditional water rights and are beginning to farm again. The jury is still out on these programs.

But if we look overseas to Sweden, Japan, Great Britain and elsewhere, we can see how social policies have paid off in improved health and life expectancy. One set of policies—such as free universal child care—tend to decouple exposure to health benefits or health threats from an individual’s own wealth level. The other kind—such as income supports for parents and redistributive tax policies—tend to flatten nations’ inequality.

Class and racial inequities in the United States and the health disparities they influence are not “natural.” They are the products of decisions that we as a society have made—and can make differently. Other nations already have. Equity and justice are not simply fine sounding ideals. They have life and blood consequences.